



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

[Injured Employee]

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-13-2364-01

MFDR Date Received

MAY 14, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following documents are about the MRI I had done on 9/29/12. My doctor considered this MRI necessary and also thought [sic] it would be denied again by I.C., so I paid myself on 9/29/12 a total of \$800 to Southwest Diagnostic Imaging Center which is the receipt I'm send to you. The other is a bill for the radiologist's professional fees which hasn't been covered yet for amount of \$484."

Amount in Dispute: \$800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the disputed services. That payment, however, will only be the fee schedule amount of \$706.25. The requestor will have to seek refund of the balance from the particular healthcare provider involved who accepted payment from the claimant."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy. 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 29, 2012	Radiological Services – MRI – W/WO Contrast	\$800.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured workers' out of pocket expenses for the compensable injury.
3. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - 920 – Reimbursement is being allowed based up a dispute.

Issues

1. Did the requestor pay out of pocket for medical expenses incurred for the compensable injury?
2. Was the requestor reimbursed correctly?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the documentation submitted by the requestor finds that the injured employee did pay for the service in dispute. The respondent submitted proof of reimbursement to the injured employee in the amount of \$706.25, which is \$93.75 less than the amount the injured employee paid out of pocket for the MRI With and Without Contrast. The respondent states in their position summary that "The requestor will have to seek refund of the balance from the particular healthcare provider involved who accepted payment from the claimant." In accordance with 28 Texas Administrative Code §133.270(d) the injured employee may seek reimbursement for any payment made above the division fee guideline or contract amount from the health care provider who received the overpayment.
2. In accordance with 28 Texas Administrative Code §134.203 the maximum allowable reimbursement for the services in dispute is \$870.26. The amount the injured worker paid out of pocket for the MRI, \$800.00, was less than the MAR. The respondent was contacted and they agreed to submit the addition \$93.75 to the injured worker as the MRI the injured worker paid for was with/without contrast and the respondent issued payment for an MRI without contrast only. The respondent has submitted copies of the EOBs and checks, numbered 1096117 in the amount of \$706.25 and 11000887 in the amount of \$93.75.
3. Review of the submitted documentation finds that the injured employee was reimbursed for his out of pocket expenses.

Conclusion

For the reasons stated above, the Division finds that the requestor has been reimbursed for the out of pocket expenses incurred. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	September 30, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.